INSTRUCTIONS FOR THE 01A / F-1612 FORMS

PURPOSE

To help field providers in the proper, complete, and accurate documentation of prehospital care using ICEMA Run Report Forms. The 01A Narrative Form serves as the regional version of the EMT-P's Patient Care Record (PCR) as required in Title 22, Division 9 of the California Administrative Code (EMT-P regulations). The computer readable F-1612 data form is a data collection instrument designed to provide all core data for quality assurance, statewide and regional EMS system evaluation. Questions regarding completion of these forms, or to arrange a class teaching the use of these forms, contact ICEMA at 909-388-5823.

MARKING THE FORM

The 01A Form is a 4-part form printed on carbon less, pressure sensitive (NCR) paper. EMS personnel completing the form must make marks with a standard ink pen heavily enough to leave a legible impression on all copies. We recommend placing the form on a clipboard or other hard surface while you are making marks. When completing the reverse sides of the form, write on each form separately as the NCR paper will cause marks on the front of the O1A form.

DISPOSITION OF COPIES

WHITE:
The EMS service provider agency will keep the ***white*** (original/first part) copy of the 01A form.

GREEN:
The ***green*** copy of the 01A form becomes part of the patients' medical record for the receiving hospital. It is to accompany the patient to the receiving hospital for inclusion in the patient's medical record. When a transporting service provider (ambulance) arrives and prepares to transport, the first service provider agency will give their green medical copy to the transporting agency, even if the 01A form has not been completed. The 01A form may then be completed after the patient has left the scene, noting that fact in the comments. Do NOT have the patient wait for transporting while you are completing a form.

YELLOW:
The EMS service provider agency will send ***all designated yellow*** copies of the 01A form to ICEMA each month. ***Designated copies*** **are 1) patients under 18 years of age, 2) expanded scope skills, 3) expanded scope medications, and 4) ET attempts**. ICEMA reserves the discretion to request additional 01A forms from each agency. The Agency EMS Coordinator, and/or the assigned Base Hospital PLN must review each 01A with expanded scope skills and/or medications before sending them to ICEMA.

PINK:
The ***pink*** copy of the 01A form serves as a billing or extra copy for the EMS service provider agency (the field provider's employer). This copy may be used for educational purposes or prehospital research that is being conducted. It may be sent to the base hospital or other requesting party as requested. When using this copy for outside agencies, black out the patient's name and any personal identifying information.

WHEN TO COMPLETE A FORM

For every patient contact, a 01A form is required, including interfacility transfers. Each patient on scene will have a separate form completed. Each ALS provider, who makes patient contact, must complete a 01A form for that patient. Separate crews from the same provider that give care to the same patient, must complete a separate 01A form for the care they gave. Record items that reflect only those services provided by the person(s) completing the form. When one provider takes over care from another, record the ICEMA number from the 01A form completed by the transferring care provider in the space titled "Other ICEMA #."

EMERGENCY CALLS
EMT-P'S must completely fill out a 01A form for every emergency call where patient contact is made.
Exceptions are as follows:

1. Weight may be left blank if not used for treatment;
2. Mechanisms of injury should be blank for non trauma patients;
3. Zones may be blank if not applicable to the local area;
4. EKG rhythm should be blank if no EKG is done.

INTERFACILITY TRANSFERS
For reporting purposes, an "interfacility transfer" is a call on which a patient is transported from a hospital to another health care facility or other location. This includes calls on which they took a patient from a hospital to a nursing home (or vice versa); from a hospital to the patient's home; or from a hospital to another hospital. **ALS interfacility transfers (paramedic on the unit) require both a 01A Narrative form and a F-1612 data form.**

The following 01A Form items are to be completed for all ALS interfacility transfers:
1. patient name, home address and zip code
2. patient age and sex
3. chief complaint
4. blood pressure, respiration rates, respiratory efforts, capillary refill, eye opening
5. verbal response, motor response
6. head-to-toe physical assessment
7. care rendered (if any), response to treatment rendered and time administered
8. incident number
9. run dates
10. unit number
11. location (address of facility where patient is picked up)
12. times call for transport received
13. time dispatched (en route)
14. time of arrival at transferring hospitals
15. time departed a transferring hospital
16. time arrived at destination facility
17. receiving hospitals (or facility) code (for location to which patient transferred)
18. attendant signatures(s)
19. signature of person receiving the patient at the destination facility

CANCELED CALLS
A call is considered "canceled en route" when the dispatcher notifies the unit that they have canceled before the unit arrives on scene; that is, **before they make patient contact**. A **01A FORM IS NOT REQUIRED for a call that is canceled enroute**. We recommend that provider agencies use a form for data collection (for example, a dispatch report form) that contains, at a minimum, the following information:

1. incident number
2. run dates
3. incident cities
4. time call received
5. time en route to the scene
6. run code to the scene
7. call outcomes ("canceled en route")
8. attendant certification number(s)
9. provider and unit number

DRY RUNS
For reporting purposes, a "dry run" is a call on which **no patient contact is made at the scene. A 01A FORM IS NOT REQUIRED FOR THIS TYPE OF RUN.** However, if patient contact is made, and the patient refuses treatment or transport, an O1A form is required. For dry runs with no patient contact, provider agencies may use an alternative method of data collection of their choice that contains, at a minimum, the following data:

1. incident number
2. run dates
3. incident cities
4. time call received
5. time en route to the scene
6. run code to the scene
7. Call outcomes ("dry run-no pt.")
8. attendant certification number(s)
9. provider and unit number

DETAILS FOR COMPLETING THE PCR 01A NARRATIVE FORM

CANCELED ~ AMA ~ TRANSPORT ~ AIR
Mark the appropriate box for the run.

ICEMA NUMBER
The preprinted ICEMA number is located at the upper left corner of the 01A Narrative form. Mark this number on the corresponding F-1612 data form in the spaces provided for "ICEMA #" (central bottom portions of the data form).

PRIM. INC. #
Obtain this number from the dispatcher, normally after completion of the call. This is the incident (dispatch) number of the provider agency that sends the unit to the scene. Write the number in the space shown.

OTHER PROVIDER
Document the transporting agency's abbreviated name and the unit number of the vehicle when you transfer patient care to another provider for transport.

DATE
Write the date on which the provider agency received the call. Use a six-digit number. For example, enter 06/01/02 for June 1, 2002.

UNIT
This space is for the unit number (as assigned by the provider agency) of the vehicle that responded to the incident.

LOCATION OF CALL
Write the location of the incident as supplied by the agency dispatcher. Record the street number and street name when available. If they do not provide these items, record the cross streets and nearest city or community. Do not write "home" or "same."

CITY
Write the name of the city where the incident occurred. Use this to decide the city code entered on the F-1612 data form.

ZONE
Use this space to record the State Fire Marshall's fire demand zone number or the zone within a city designated by an EMS provider agency. ICEMA does not require the zone, use at the discretion of the provider agency.

NAME ~ ADDRESS ~ CITY ~ STATE ~ ZIP
Write in the patient's full name (first name, middle initial if any, and last name) on the line provided near the top of the form. Write the patient's street address, mailing address if different, the city where the patient resides, two-letter postal abbreviations for the state, and zip code on the second blank line. While on scene, and the patient is in a life-threatening situation or unable to provide an address, obtain the information from hospital personnel at the receiving hospital.

PHONE
Record telephone number to include area code.

SOCIAL SECURITY NUMBER
Enter nine-digit number.

AGE
After identifying the patient at the scene and inquiring about his or her age, record the age in years in the space shown.

DOB
Record the patient's date of birth in 6-digit format, for example, 01/01/02.

M/F
Record the patient's sex. Check the box before "M" for male, or "F" for female.

APPROX. WEIGHT
For all pediatric patients, write the patient's weight, in kilograms, in the space provided. For adults, record the weight only if necessary to treatment (for example, if drug dosage for patient condition depends upon body weight).

APPROX. HEIGHT
For all pediatric patients, record the patient's height, in feet and inches, in the space provided. For adults, record height only if weight is also necessary.

PT __ OF __
Enter assigned patient number out of total number of patients transported.

CARE PRIOR TO ARRIVAL
Check the appropriate box for the type of emergency care given prior to your unit's arrival.

1. None: No prior care.
2. CPR: If started prior to your arrival on scene
3. Other BLS: Any procedure listed in the Care Rendered-left column on the F-1612 data form.
4. ALS: Any procedure listed in the Care Rendered-right column on the F-1612 data form.

PRIOR CARE GIVER
Mark the appropriate box to show the type of agency/individual providing care prior to your unit's arrival on the scene.

1. CITZ.: a citizen, bystander, or relative provided care.
2. None: no prior caregiver.
3. Medical: physician, nurse, first responders, ski patrol, or other trained medical person on a scene provided prior care.
4. FD/BLS: a BLS unit provided prior care.
5. Law Enforce: police, sheriff, or other law enforcement personnel provided care.
6. FD/ALS: a non-transporting ALS unit provided prior care.
7. ALS Amb: ALS ambulance personnel provided prior care.

RECEIVED
Time call is first received by EMS Provider Agency. This time may be received from the dispatcher after completion of the call. Write the time, in hours and minutes, using military time (a 24-hour clock) in the box provided. Valid times range from zero (midnight) to 2359 (11:59 p.m.). **Do NOT use 2400. Note**: For walk-in patients, the time call received is when the patient walks in the door; depart is when the patient leaves; and all other times are blank.

EN ROUTE
Time that the response unit begins physical motion; i.e. wheels begin to turn.

ARRIVE
Time the EMS unit stops physical motion at scene on staging area; i.e. wheels stop turning. (Last place that the unit vehicle stops prior to assessing the patient.)

PT. CONTACT
Time response personnel establish direct contact with patient.

DEPART
Time when the response unit begins physical motion from scene, i.e. when the wheels begin to turn. If you transport a patient, record DEPART as the time the ambulance leaves the scene enroute to the hospital or other destination. If the unit completing the run is not transporting the patient, record DEPART as the time when the unit is available for another call. If the patient refuses transport, record DEPART time as the time that you leave scene.

ARRIV. DEST/END CALL
Time when patient arrives at destination or transfer point, i.e. wheels stop turning. Leave blank if your unit is not transporting the patient. Note**: Time call ended; i.e. AMA, the time a non-transport provider transferred care to a transport provider.**

AVAILABLE
Record the time that the unit is back in service and available for another call, whether they transported the patient or not.

CODE EN ROUTE
Circle the number that corresponds to the definitions below by which the unit responded to the incident:

(1) Non-Emergent, no lights or sirens
(2) Urgent, obeying all traffic regulations, no lights or sirens
(3) Emergent, with lights and sirens

CODE DEPART
Circle the number that corresponds to the mode of transportation the ambulance utilized enroute to the hospital (1, 2, or 3, as described above). If transportation does not occur, leave this item blank.

ODOMETER
Use this section as directed by your employer. ICEMA does not require odometer readings.

FAC. CONTACTED
Write an abbreviation for the base hospital contacted on this call. If the unit never attempted to make voice contact with the Base Hospital, write "none." If the Base Hospital was successfully contacted, mark the type of instrument/frequency utilized:

1. BH: Base Hospital
2. VHF: EMS/HEAR radio
3. UHF: Bio-com
4. Phone: Land line telephones
5. CELL: Cell phone
6. 800Mhz: San Bernardino County system
7. None: In Radio Communication failure record the BH name

CONTACT TIME
Record the time contact was initiated with the base hospital.

RECEIVING HOSPITAL
Record the name or appropriate abbreviation for the hospital where the patient was transported.

Mark the ONE category that best describes the reason for selection of the receiving hospital:

Pt. Request:	patient or patient's physician requested this facility
Diversion:	the original receiving hospital selected was on diversion for this type of call
Trauma:	transported to this facility because they require a trauma center
RCF:	radio communication failure
Peds trauma:	they require a pediatric trauma center
Reroute:	the receiving hospital destination changed while the unit was en route from scene. E.g., a change in patient condition required selection of a different facility). Not to include change in the destination based upon hospital status (see "diversion")
Closest:	the hospital is selected because it is closest to the scene
Other:	a reason other than those listed above in selecting the receiving hospital

CHIEF COMPLAINT
Use the blank space under this heading to describe details of the patient's problem. Describe the location of injury; (head, face, neck, chest, abdomen, rt. or lt. arm or leg, rt. or lt. hand or foot), or sites of pain; the type of injury or pain (e.g., fracture, laceration, etc.), and other medically relevant signs and symptoms (e.g., estimated blood loss). Include drug or alcohol use here.

MECHANISM OF INJURY
For all trauma patients, record the reported cause of injury. Categories include motor vehicle accidents (MVA), motorcycle collisions (MCA), GSW, stabbing etc. For falls, specify if more than 20 feet. Show whether injury is blunt or penetrating. If undeterminable, write "unknown." Circle “Y”-yes or “N”-no to the following questions; did the patient wear a helmet, a seat belt, have a loss of consciousness (LOC), and was an airbag inflated?

MED. HISTORY
Use this space to record the patient’s medical history. History may include cardiac, respiratory, liver, kidney, or other known disease, any recent and/or related illnesses, medical conditions, hospitalizations, history of trauma, or medical treatments. Also, record the time of injury or time of onset of symptoms as stated by the patient. Check appropriate predesignated diagnosis if one applies to the patient.

MEDICATION
Write the names of all prescription or over-the-counter medications the patient is currently taking. Abbreviate as necessary. If they do not know the specific name of the drug, record the class of drug or the action it takes (e.g., insulin, diuretic, an antidepressant, antihistamine, etc.). Include dose and frequency if it is taken daily (e.g., Bid, T.i.d., QD). Bring any medication not quickly identifiable to the hospital with the patient.

ALLERGIES
Mark the box ‘NKA’ for no known allergies. Otherwise, record the names of any medications to which the patient has had an allergic reaction. Also record any other allergies either related to the current problem (for example, the mechanism of injury is "bite/sting" and the patient is allergic to bee stings), or environmental allergies (for example Latex allergies).

BLOOD PRESSURE
Record the time (use a 24-hour clock) and initial blood pressure reading as systolic/diastolic. Note if auscultation or palpation was used to obtain B/P. Record blood pressure readings as required by protocol. If you require additional space, use the Narrative section.

PULSE
Record the rate and quality of the pulse (e.g., thready, bounding, irregular). Use appropriate abbreviations (e.g., 70 norm., 60 irreg.). Record repeated pulse rate and quality as required by protocol. Use the Narrative section for additional space, if required.

RESPIRATION
Record the rate, number of respiration's per minute/quality of respiration's (e.g., clear, wheezes, rales, unequal, or absent). Record repeated respiratory rate and quality as required by protocol. Describe lung sounds as auscultated with a stethoscope. Use the Narrative section for additional space, if required.

PULSE OX
Give numeric value as a percentile and whether it was taken on room air or with supplemental oxygen.

SKIN COLOR
Mark the category that most closely matches the patient's skin color upon initial assessment: normal, pale/ashen, cyanotic, or flushed. Check box "A" for first time observed and box "B" where a vital sign is repeated record time for "A" and time "B" in line provided.

MOISTURE
Mark how much skin moisture noted on initial assessment: normal, dry, moist, or profusely diaphoretic.

SKIN TEMP
Mark the patient's skin temperature as noted on initial assessment: hot, warm, cool, or cold.

PUPILS - LT (LEFT) RT (RIGHT)
Mark the boxes that best describes the pupillary response or status upon initial assessment of the patient. Separate columns are provided for description of pupillary response in left and right eyes.

RESPIRATORY EFF.
Record the patient's visible respiratory effort (chest wall movement), mark the box next to the category that better describes the present condition for this patient--normal, or abnormal (shallow/retractive/none).

1. Normal: easy, unlabored, deep respirations.
2. Shallow: diminished volume of respirations.
3. Retractive: this involves the use of the accessory and/or abdominal muscles for breathing.
4. None: mark if patient has no apparent respirations.

If no box is marked, it will be assumed that no assessment was done.

CAPILLARY REFILL
Mark the box next to the category that best describes the patient's capillary refill upon assessment.

1. Immediate: return of color in two seconds or less.
2. Delayed: color does not return in less than two seconds
3. None: no return of color.

EYE OPENING
Note the patient's initial ability to open his/her eye(s). Mark the box next to the appropriate category.

1. Spontaneous: patients' eyes open without stimulation; patient can close eyes upon request.
2. To voice: eyes open when the patient's name is spoken or shouted.
3. To pain: eyes open in response to a standard pain stimulus.
4. None: eyes do not open despite a stimulus.

VERBAL RESPONSE
Mark the box next to the category that describes this patient's initial best verbal response.

1. Oriented: correctly responds when asked name, place, date, and history of an event.
2. Confused: incorrectly responds to questions, but can produce phrases of more than two
3. Inappropriate: able to produce only an intact word or two in response to physical stimulation.
4. Incomprehensible: able to produce sounds (mumbling or groaning), but no words.
5. None: no verbal response to any stimulation.

MOTOR RESPONSE
Mark the box next to the patient's initial best motor response.

1. Obedient: Pt. ability to comprehend, physically execute a spoken or written instruction.
2. Purposeful: patient responds to a standard pain stimulus.
3. Withdrawal: no verbal response; the elbows flex rapidly with no muscle stiffness.
4. Flexion: no verbal response; the elbows flex slowly and muscle is stiff.
5. Extension: no verbal response; arms and/or legs out; muscles are stiff.
6. None: no verbal or motor response.

PULSE
Mark the box next to the appropriate area (Femoral, Radial, Carotid) as present or absent.

GCS
Enter the GCS (Glasgow Coma Scale) and include in report to base hospital.

PT PHYSICIAN
Enter name of patients' physicians, if known.

TEMP
Enter patients' body temperature and location taken (oral, tympanic).

BLOOD GLUCOSE D50/D25
Enter blood glucose numeric value before D50/D25 was given and enter a secondary numeric value for the repeat blood glucose after the administration of D50/D25.

END-TIDAL Co2 DETECTED
If the patient is intubated, note detection of Co2 after placement, before the patient is moved and after moving patient.

SECONDARY SURVEY
Mark the box for the appropriate category in each section of the "**neuro/head**" survey.

WNL: within normal limits.
N/A: not applicable.
ABN: abnormal.

In the comments section next to "**neck**", mark box if no JVD (jugular venous distention); next to "**chest**", mark if negative barrel hoop; next to "**abdomen**", mark if soft and/supple; next to "**back-spine**", mark if full spinal immobilization was instituted (this constitutes rigid collar, head/chin straps, head bed, long board and straps); next to "**pelvis**", mark box if negative or no instability noticed; next to "**extreme**", mark box if no distal edema and if the patient has full range of motion.

NARCOTIC GIVEN ~ NARCOTIC WASTED
Enter the amount of the narcotic given to patient. Enter the amount, date, time, and location where narcotic was wasted. The EMT-P and the Nurse who witnessed the waste of the narcotic must sign in the appropriate area.

EKG - DEFIB RHYTHM
When an EMS field provider places a patient on the monitor, this area must be completed. Do not record a rhythm obtained by another unit. Record the initial and any subsequent rhythms in the spaces provided. Enter energy level in joules if patient is cardioverted or defibrillated, and rhythm following procedure. If TCP is utilized note capture, rate and amperes used. If additional space is needed, continue in the Narrative/Assessment section.

CARE RENDERED
Record the time that any medication or procedure was ordered or initiated by the EMT/Paramedic, using the 24-hour clock format. Identify medications and procedures prior to Base Hospital contact with the abbreviation "PTC" immediately following the time. **Be sure to include all types of treatment in this section. Record only those treatments provided by attendants signing this form.** Record the time when each procedure was initiated. Include RT/Size-route and size of appliance used, dose and response to treatment in sections provided. Record the complete name of all drugs administered, with the time ordered, route, dose, and time administered. Use abbreviations as necessary. If the Base Hospital ordered, medications or procedures but where not completed please note that fact in this section

PQRST
Record in the PQRST box as applicable.

"P" Provoke-what provoked pain?
"Q" Quality of pain-sharp/dull?
"R" Radiate-where does the pain radiate?
"S" Severity-have the patient rate on a 1-10 scale how severe they feel the pain is, one being the least pain they've experienced and 10 being the worst.
"T" Time-how long have they had the pain?

NARRATIVE/ASSESSMENT
Use this section for details concerning the patient. Include exceptions and unusual conditions or circumstances. Record the type of care administered prior to arrival of this unit. Overall change (or no change) in patient condition. Do not record personal opinions. Note pertinent negatives in physical assessment and response or change after care rendered. Use **ICEMA Supplemental Patient Report** form if more space is needed.

3 TEAM MEMBER SIGNATURE AREAS
This area is for the name and Accreditation/Certification number of the team members. Mark the appropriate box for each team member.

1. Patient Attendant: The team member responsible for patient care.
2. Radio Attendant: The team member who made contact with the Base Hospital.
3. Completed form: The team member who actually completed the O1A form.
4. Other: Mark this box if there is a third member (trainee or ride out).

FORM NOT COMPLETED ON SCENE
Mark this box when the O1A form is not completed on scene.

PT RECEIVED BY
The physician or nurse taking responsibility for the patient must sign this area upon arrival at the receiving hospital or facility. When an air ambulance takes a patient from a ground ambulance for further transport, the person on the air transport crew will sign here. They now assume responsibility for patient care. The ground ambulance gives the second green copy of the form to the person whose signature appears in this area.

REVERSE SIDES OF FORM
The reverse sides of the original and three copies of the 01A Narrative form contain additional printed information. When filling out the reverse sides remember to write only on the form you are using.

BACK OF FIRST (WHITE) COPY

BILLING INFORMATION
This is the provider's copy. Complete this section as directed by your employer. ICEMA does not require completion of billing information.

MEDICAL/LIABILITY RELEASE FORM
If the patient refuses treatment, have the patient complete the "Medical Liability Release Form" on the back of the first copy (white) of the 01A Narrative form. If the patient is a minor, also have the parent or guardians sign the release. Sign the release in the area for Witness 1, and obtain the signature of a second witness. If Base Hospital contact was made, mark the box next to "Yes" on the bottom of the release; otherwise, mark "No". Document in the Narrative all pertinent information regarding the incident.

PHYSICIAN'S RESPONSIBILITY
If a physician on scene states a desire to take charge of the patient, he or she must show a current California Medical Physician's License. The doctor must read the "Physician's Responsibility" statement on the back of the first copy (white) of the 01A form and must sign the form, including his or her license number and expiration date. Make Base Hospital contact and state that a physician is on scene requesting to take medical control of the patient. **If the Base Hospital physician agrees to relinquish control** you may perform any procedure or give any medication approved for use in the ICEMA region under the direction of the physician on scene. This physician must accompany the patient to the receiving facility in the ambulance. The field provider must complete the 01A form as usual.

BACK OF SECOND (GREEN) COPY

THROMBOLYTIC ASSESSMENT
This checklist should be completed while enroute on all chest pain patients. This information should be conveyed to the Base Hospital as soon as possible.

BASE HOSPITAL/RECEIVING FACILITY
These codes are to be used to identify the Base Hospital/Receiving Facility

RULE OF NINES CHART
This chart is included to assist the provider in determining burn percentages for the adult and pediatric patient.

APGAR SCORING
This chart is available for use in assessment of the newborn infant.

STANDARDIZED ABBREVIATIONS
These should be used consistently throughout the completion of the form. If an abbreviation is questionable, completely spell out the word so it is clear and concise to any individual reading the form.

BACK OF THIRD (YELLOW) COPY
This completed form must be given to the Base Hospital PLN; if patient is transported there, OR given to your QI/EMS Coordinator if patient transported to another facility. Complete for evaluation of the advanced skills: Adult Endotracheal Intubation, Pediatric Endotracheal Intubation, Nasotracheal Intubation, Percutaneous Needle Cricothyrotomy, Intraosseous Infusion, Transcutaneous Cardiac Pacing.

1. In space provided **record the patient's name** as written on the original 01A form.
2. Record the ICEMA run report number in space provided from the front of the 01A form.
3. Check all the procedures utilized in the boxes provided.

INTUBATION
Check the box provided for an adult or pediatric patient. Then mark the route used, (nasal or oral). Enter size of ET tube, number of attempts made and yes or no to if the procedure was successful.

NEEDLE CRICOTHYROTOMY
Enter the size of the needle, or name of the approved device, number of attempts, and if the procedure was successful.

INTRAOSSEOUS INFUSION
State the size of the IO catheter, number of attempts, and if the procedure was successful.

PLACEMENT VERIFIED
Document how you verified proper placement of device/procedure.

TRANSCUTANEOUS CARDIAC PACING
Document if the transcutaneous pacer captured the rhythm:

1. HR — The rate at which the pacemaker captured.
2. AMP — The amplitude needed to capture.
3. Palpable pulse rate — The palpated HR in beats per minute.
4. B/P — Blood pressure after pacing achieved.
5. Atropine given — Yes or No.

PULSE OXIMETRY
Record numeric value in a percentage of O2 present before treatment and after treatment.

END TIDAL CO2
Record if detected-yes or no, and percentage detected.

IF THE PROCEDURE YOU USED WAS SUCCESSFUL
Explain in the narrative the patient's response to treatment.

IF THE PROCEDURE YOU USED WAS UNSUCCESSFUL
Explain in the narrative what you felt inhibited the procedure from being successful (e.g., irreg. Anatomical structure, broken equipment, incorrect placement, etc.).

FIELD ASSESSMENT/TREATMENT INDICATORS
Document all the patient indicators for the procedure performed.

PROCEDURE PERFORMED
Document how procedure was performed: prior to contact, in radio communication failure (RCF), or upon base hospital order.

OTHER DOCUMENTATION
Document the name of the Receiving Facility, and/or the Base Hospital. Have receiving hospital physician sign the form in the space provided. The paramedic who completed the skill and the evaluation form signs the form in the space provided. The paramedic must give this form to the PLN at the contacted Base Hospital for review if the patient was transported to that facility or to their QI/EMS Coordinator if patient was transported to another facility.

PLN DOCUMENTATION
This area needs to be completed by either the PLN or QI/EMS Coordinator and sent to the ICEMA ALS Coordinator with a photocopy of both sides of the 01A form on a monthly basis.

BACK OF FOURTH (PINK) COPY

MULTIPLE PATIENT TRIAGE FORM
This area is provided to assist with multiple casualty incidents. This form is to help the team members with rapid patient assessment and organization. **Each patient requires a separate 01A Form and F-1612 data form**.

PATIENT TRANSPORTATION RECORD/MCI WORK SHEET
This is a work sheet provided to assist the paramedic with keeping track of where multiple patients are transported during a MCI. For each patient, enter:

1. name of the transporting agency
2. patient's triage tag number
3. approximate age and sex (M or F)
4. patient's triage priority status; "**I**" for immediate, "**D**" for delayed, or "**M**" for minor

Enter a brief description for chief complaint, and ETA in minutes from scene departure to arrival at receiving hospital. Record "Off Scene Time" as the time the transporting unit leaves the scene**. Following initial triage, complete a full set of Run Report Forms for each patient**. Information recorded on the multiple patient triage form can transfer to the front of the individual patient's 01A form.

INSTRUCTIONS FOR COMPLETING THE PCR F-1612 DATA COLLECTION FORM

MARKING THE FORM
The F-1612 data form is to be completed separately from the 01A form. Complete all marks on this form within the boxes or "bubbles" in ink, (any dark color except red) or a black pencil. Mark only designated boxes. No other marks or comment should appear. For optimal scanning, **do not fold, staple, paper clip, or bend this form.** The scanner will read any other writing, lines, or comments as data, even if intended as a line or comment. 'MONO Correction Tape', by TOMBOW, may be used to make corrections instantly cleanly completely and remark the error directly on film. This product is a timesaving option. White out correction fluid may also be used to correct marks made in error. Apply a thin coat; thick fluid jams the form in the scanner. In addition, use care not to white out any of the black marks along the left side of the form. Do not make any marks or let white out run in the lower left corner of the form (below "Outcome" and "Why Selected").

DISPOSITION OF FORM
Field providers will send completed F-1612 data forms to ICEMA for data processing and quality assurance review 30 days following the run date. Agencies using electronic data submission will also send their data 30 days following the run date.

WHEN TO COMPLETE A FORM
For every patient contact, including interfacility transfers, an F-1612 data form is required. If more than one patient is at the scene, a separate form must be completed for each patient. If two providers are dispatched to the same scene, each ALS provider who makes patient contact must complete an F-1612 data form. **Items recorded on the forms should reflect only those services provided by the person(s) completing the form.** For example, when one ALS unit arrives first on the scene, the paramedic would record all care rendered to the patient on their F-1612 data form. If another ALS provider takes over care, the second paramedic would record treatment performed by its personnel on a separate F-1612 data form and will write the ICEMA number of the form completed by the first ALS provider in the space for "Other ICEMA #."

EMERGENCY CALLS
For every emergency call where patient contact is made, all sections must be completed on the F-1612 data form. **Exceptions are as follows:**

1. Mechanisms of injury should be blank for non-trauma patients.
2. EKG rhythm should be blank if no EKG is done.
3. Medications administered should be left blank if no medications where given.

INTERFACILITY TRANSFERS
In addition to the 01A narrative form, the F-1612 data form must be completed for all ALS interfacility transfers. If a hospital request a BLS transfer but they send a paramedic on the run (with or without an EMT-I), an F-1612 data form is required. If the provider makes a BLS transfer with a nurse but no paramedic, we require only the 01A

form.

ALS interfacility transfers (paramedic on the unit) require both an F-1612 data form and a 01A Narrative form. The following F-1612 data form items are to be marked for ALS interfacility transfers:

1. patient sex, age, and zip code
2. number of patients
3. incident number
4. rundate (date transported)
5. city code (for the city where the transferring facility is located)
6. run code to the scene
7. category (marked "transfer")
8. receiving hospital code
9. times call for transport received
10. time enroute
11. time of arrival at transferring hospitals
12. time departed a transferring hospital
13. time arrived at destination facility
14. systolic BP, respiratory rate and effort, capillary refill, eye opening
15. verbal response, motor response
16. care rendered (ALS or BLS if any during transport)
17. response to treatment rendered and time administered
18. medications (Note: Medications that are being monitored, i.e. Magnesium Sulfate drips)
19. patient condition (change/no change enroute)
20. outcome
21. attendant accreditation/certification numbers
22. provider and unit codes

CANCELED CALLS

A call is considered “canceled enroute” when the dispatcher notifies the unit that they have canceled the call before the unit arrives on a scene or before patient contact is made.

The following F-1612 data form items are to be marked for calls canceled enroute:

1. incident number
2. run dates
3. incident city code
4. run code to the scene
5. time call received
6. time enroute to the scene
7. call outcomes ("canceled enroute")
8. attendant accreditation/certification number(s)
9. provider and unit numbers

DRY RUNS

For data collection a “dry run” is a call on which **no patient contact is made at the scene**. Although the 01A form is not required for this type of run, an F-1612 data form is required. If patient contact is made at the scene and refuses treatment or transport, the F1612 data form is still required.

The following F-1612 data form items are to be marked for dry runs:

1. incident number
2. run dates
3. incident city code
4. run code to the scene
5. time call received
6. time enroute to the scene
7. call outcomes (“dry run-no pt.”)
8. Attendant accreditation/certification number(s)
9. Provider and unit numbers

DETAILS FOR COMPLETING THE F-1612 PCR DATA COLLECTION FORM

The F-1612 data form should be completed as soon as possible after the call, while the details of the run are fresh in your mind. All marks on the form must appear within the "boxes." *Data recorded here must match corresponding items on the 01A Narrative form for the patient*. No extra comments or writing should appear on the F-1612 data form, as the scanner will read the data incorrectly.

SEX (*Fieldname: GENDER*)
To show the patient's gender, mark the appropriate box **(M)ale, (F)emale** or **(U)nknown** (if the sex cannot be determined). **Do not mark more than one box**. The scanner reads a mark in the box for "M" that extends into the next box for "F" as a question mark, causing an error in the data.

AGE
Mark two numbers, **(0-9)**. Mark the numbers under the heading "Age" that match the number of whole years in the patient's age. If the patient is less than one year old, mark two zeroes ("00"). If they state the patient's age as "18 months," mark ("01") in the numbers below "Age." If they state the patient's age in half-years, for example as "two and a half," record only the whole number of years (marking the numbers "02"). If the patient is more than 99 years old, mark two nines ("99"). When the patient is obviously dead, attempt to get age from another party at the scene who knows the patient, or estimate the patient's age.

ZIP
Mark the numbers **(0-9)** beneath the heading "Zip" that represent the **first five digits of the patient's zip code**. If the patient is homeless or in transition or for some other reason has no zip code, make no marks in this section. For patients from outside the United States, mark 99999.

#PTS (*Fieldname:* PTS)
Record the number of patients encountered under the heading "# Pts" by marking the box with the appropriate number **(0-9)**. If you encounter more than nine patients at the scene, mark the box for ">9". Both the 01A Narrative form and F-1612 data form must be completed for each patient. This item is used to count multi-casualty incidents for statistical reporting. For example, a three-victim motor vehicle accident would have three forms, with "Number patients" marked "3" on each form--three different ICEMA numbers, with one incident number.

INCIDENT #
Mark eight boxes **(0-9)**. Using the dispatch number recorded on the *01A narrative under "Prim. Inc. #,"* mark the corresponding numbers below the heading for "Incident #." If the incident number is less than eight digits, mark zeroes to fill the boxes to the left of the incident number.

RUNDATE (*Fieldnames:* RUN-YEAR1 (9,0,1)/RUN-YEAR2 (0-9)/RUN-MONTH (0-9)/RUN-DAY (0-9))
Mark six boxes. Mark the numbers below the heading "rundate" that match the date written *in the "Date" area of the 01A Narrative*. Use 6-digit format and marking zeroes as necessary for the month and day, year, e.g., 06/01/02.

CITY
Mark three boxes **(0-9)**. Refer to the Incident City Codes listed on the back of the F-1612 data form. Find the three-digit code number across from the name of the city where the incident occurred. Mark the numbers beneath the heading "City" that represent this three-digit city code.

RUN CODE (*Fieldnames:* RUN TO CODE/RUN FR CODE)

Definitions:

(1) Non-Emergent, no lights or sirens
(2) Urgent, obeying all traffic regulations, no lights or sirens
(3) Emergent, with lights and sirens

RUN TO CODE: Mark the number **(1, 2 or 3)** of run codes enroute to the scene. This should be the same number as that circled for *"Received Code" on the 01A Narrative*:

RUN FR CODE: Mark the number **(1, 2 or 3)** of run codes from the scene to the receiving. This should be the same number as circled for *"Depart Code" on the 01A Narrative*. If you make no transport, leave this item blank.

OTHER TRANSPORT PROVIDER/UNIT (*Fieldname*s: PROVIDER A/UNIT A)

Record the provider code **(0-9)** of another provider on scene. If your unit is the first on a scene and transfer patient care to another unit for transport, refer to the "Other Provider" area of the 01A Narrative. The transporting Provider Code list is on the back of the F-1612 data form. For fire departments, this code is "000." Record the 3-digit provider code and the unit number of the transporting unit. Complete this section only if a second unit is on scene and makes patient contact. **Use 777 for transport by any private car, truck, or other vehicle** that transports the patient (citizen transport). **Use 888 for transport by any provider that does not have an assigned code**, including transport by agencies outside the region.

TRANSP CODE1 (OTHER TRANSPORT)

Mark the type of unit **(MA, MS, ME, AM, SQ, E)** for another provider on scene. Enter this information only if a second unit is on scene and makes patient contact.

(MA)Medic Ambulance
(MS)Medic Squad
(ME)Medic Engine
(AM)Ambulance
(SQ)Squad
(E)Engine.

OTHER ICEMA# (*Fieldname:* ICEMA#1)

Enter another agency's O1A Narrative form number whenever another ALS provider agency is on scene and makes contact with the same patient. (*You mark their 01A number on your F-1612 data form, and they mark your 01A number on their F-1612 data form in the "Other ICEMA #" box*.) Fill this in whenever another 01A Narrative form exists for the same patient. If only one 01A form exists for a patient, this area should be blank.

PRIOR CARE

Mark the **one** appropriate box **(N, M, B, C, O, L, A)** to show the person or agent providing care or treatment to the patient prior to arrival of the prehospital field personnel completing this form.

1. **(N)none**: no care given to the patient prior to arrival of this unit.
2. **(M)medical**: a physician, nurse, or other medical person on a scene provided care.
3. **(B)FD/BLS**: a BLS unit provided prior care.
4. **(C)citizen**: a citizen, bystander, or relative provided care.
5. **(O)other**: Some person gave prior care not fitting any of the defined categories.
6. **(L)law enf.** police, sheriff, or other law enforcement personnel provided care.
7. **(A)FD/ALS**: another ALS unit provided prior care.

MECH. OF INJURY-TRAUMA ONLY (*Fieldname:* INJURY MECH)

Mark the space next to the **one** category **(M, C, G, S, A, D, F, B, L, T, P, O, U)** that best describes the mechanism of injury precipitating this call**. This section should be left blank for non-trauma cases**.

(M)auto/truck-MVA: any traffic incident, except those involving motorcycles. This includes an auto vs. an auto, auto vs. truck, pedestrian vs. autos, single vehicle collisions, etc.

SEATBELT: **(*Fieldname*)** — **(Y)es or (N)o** to show if the patient was wearing a seatbelt or other safety restraint device. Must be completed for all motor vehicle accident calls.

(C)motorcycle: any traffic related incident involving a motorcycle or bicycle. This includes autos vs. motorcycle, motorcycle vs. pedestrian, bicycle vs pedestrian, etc.

HELMET: ***(Fieldname)***: **(Y)es or (N)o** to show if the patient was wearing a protective helmet. Must be completed for all traffic-related incidents involving motorcycles.

(G)gunshot: any call involving injury from a firearm, including a pistol, shotgun, rifle, or other similar weapon.

(S)stabbing: a penetrating injury by a knife or other sharp object.

(A)assault: any injury resulting from assault other than a gunshot wound or stabbing.

(D)near-drowning: conditions resulting from submersion that deprives the patient of oxygen.

(F)fall >20' : injury resulting from a fall from a building, ladder, or other place estimated at more than 20 feet from the area where the patient landed. Do not use this category for slips or short-distance falls such as a fall in the bathtub. **For short falls, mark "blunt injury" or "penetrating injury"** as appropriate.

(B)bite/sting: injury from any type of animal, insect bite or sting; e.g., snakes, bee, a dog bite.

(L)blunt injury: an accidental injury in which the skin is unbroken or only slightly opened.

(T)multiple mech.: more than one mechanism of injury none more notable than another. If more than one mechanism, but one dominant injury occurs with other minor injuries, check the single category that caused the dominant injury.

(P)oth penetrating: an injury other than stabbing which penetrates the skin and subcutaneous tissue.

(O)other: any condition not covered under the categories above, including ski, snow boarding, and boating accidents.

(U)unknown: the mechanism of injury cannot be determined.

CATEGORY

Mark the **one** box **(T, C, R, A, B, 5, U, D, E, O, P, S, M, N)** next to the category that best fits this patient.

(T)trauma: any serious traumatic condition except cranial and/or spinal injury, assault involving domestic violence, or amputation. If you mark this box, you must **also mark "MECH. OF INJURY."** For **ski accidents**, mark this box and "**MECH OF INJURY" as (O)ther**.

(C)cardiac: all acute cardiopulmonary emergencies including myocardial infarction or suspected heart attack.

(R)respiratory: choking incidents, asthma attacks, and other situations in which the patient's primary difficulty is failure to breathe adequately

(A)amputation: cases that involve potential re-implantation of a severed body part, cases involving complete or partial traumatic amputation of a body part.

(B)behavior/OD: intoxicated or psychologically disturbed patients, conditions related with alcohol or drug related syndromes including drug overdose, attempted suicide, and homicide victims; **does not include "5150" cases**.

(5)5150: patients transported to any mental health facility for 72-hour treatment and evaluation requested bylaw enforcement or other persons authorized to declare such treatment and evaluation

(U)burn: injury by fire, explosion, or chemical burn.

(D)domestic viol: calls involving child abuse or neglect, domestic partner abuse, elder abuse, or sexual assault. **Also specify "MECH. OF INJURY."**

(E)environment: diving casualties, radiation accidents, hypothermia, heat exhaustion, and other cases involving exposure to the elements. **Also specify "MECH. OF INJURY."**

(O)obstetric: problems relating to pregnancy, assistance with delivery, and postpartum emergencies.

(P)poisoning: emergencies resulting from ingestion, inhalation, or other exposure to toxic substances including intentional and accidental poisonings and hazardous materials' incidents; any call involving use of a poison control center.

(S)spinal inj: cranial and/or spinal trauma. **Specify "MECH. OF INJURY"**

(M)oth medical: other medical complaints such as diabetic complications, abdominal pain, or any medical problem involving a system other than the cardiac or respiratory system.

(N)transfer: any transfer of a patient from an acute care hospital to another facility.

BASE HOSP
Enter the base hospital code **(0-9)** only if BH was contacted. On the back of the F-1612 data form, find the name of the base hospital and the two-digit code next to the name. Mark the numbers corresponding to this code below the heading 'Base Hosp'.

NO HOSPITAL CONTACT-USE CODE "89"
Mark (Y)es if no BH contact attempted/needed, RCF or contact was with receiving hospital only.

Note:	**Base Hospital**	**No Contact**	**Interpreted As:**
	(blank)	Marked	no contact attempted/needed
	Marked	Marked	radio communications failure (follow RCF protocol)
	Marked	(blank)	successful base contact
	(blank)	Marked	Contact with receiving hosp only.

RECV HOSP
On the reverse side of the F-1612 data form, find the name of the receiving hospital and mark the two-digit code number **(0-9)** here. Use code **"77" for all subacute or chronic care facilities** (e.g., nursing homes). Use code "**99" for destinations other than acute care hospitals, subacute or chronic care facilities** (e.g., a residence). If the patient refuses transport or if another provider is transporting the patient, leave this item blank.

-TIMES-

CALL RECD
Time call is first received by EMS Provider Agency. Mark the numbers **(0-9)** that match the *"Received" time from the 01A Narrative form.* Use military time (a 24-hour clock). Valid times range from 0000 (midnight) to 2359 (11:59 p.m.). DO NOT USE 2400. **Note**: For walk-in patients, the time call received is when the patient walks in the door; depart is when the patient leaves; and all other times are blank.

ENROUTE
Time that the response unit begins physical motion; i.e. wheels begin to turn. Mark the numbers **(0-9)** that match the *"Enroute" time from the 01A Narrative form*.

ARRIVE (*Fieldname*: TIME ARRIVE)
Time the EMS unit stops physical motion at scene or staging area; i.e. wheels stop turning. Mark the numbers **(0-9)** that match the *"Arrive" time from the 01A Narrative form*.

DEPART (*Fieldname:* TIME DEPART)
Time when the response unit begins physical motion from scene, i.e. when the wheels begin to turn. . Mark the numbers **(0-9)** that match the *"Depart" time from the 01A Narrative form*. If you transport a patient, record DEPART as the time the ambulance leaves the scene enroute to the hospital or other destination. If the unit completing the run is not transporting the patient, record DEPART as the time when the unit is available for another call. If the patient refuses transport, record DEPART time as the time that you leave scene.

ARV DEST/END CALL (*Fieldname*: ARV DESTIN)
Time when patient arrives at destination or transfer point; i.e. wheels stop turning. Mark the numbers **(0-9)** that match the *"Arrive Dest" time from the 01A narrative form.* Leave blank if your unit is not transporting the patient. Note: Time call ended; i.e. AMA, the time a non-transport provider transferred care to a transport provider.

PT REFUSES CARE (*Fieldname*: REFUSE CARE)
Mark this area **(Y)** when a patient declines **all** prehospital treatment. In such situations, the patient must also sign the medical release section on the back of the first copy of the 01A Narrative form. If the patient refuses one or more specific types of care, document the type of care refused in the Narrative/Assessment section of the 01A narrative form.

RELEASE SIGNED
Mark this box **(Y)** when the patient refuses treatment and completes the "Medical Liability Release Form" on the *back of the first copy (white) of the 01A Narrative form.*

MEDICATIONS (*Fieldname*: MEDICATION)
Mark as many boxes **(A, H, B, J, P, K, D, 1, 2, E, Q, F, G, L, R, S, M, N, 3, W, C, 4, V, U)** as apply. Mark ONLY the box(es) given by the unit recording this run. The medications are listed alphabetically; **(A)act. charcoal, (H)adenosine, (B)albuterol, (J)aspirin, (P)atropine, (K)bretylium, (D)dextrose, (1)diphenhydram, (2)dopamine, (E)epineph-IV, (Q)epineph-SQ, (F)furosemide, (G)glucagon, (L)lidocaine, (R)magnesium, (S)midazolam, (M)morphine, (N)naloxone, (3)nitroglycerine, (W)phenylephrine, (C)procainade, (4)sodium bicarb, (V)verapamil, (U)other med, for medication(s) administered but not listed.** For Interfacility Transfers, mark boxes for medication that are being monitored by the EMT-P during the transfer.

CARE RENDERED (*Fieldnames*: CARE1/CARE2)
For service or treatment provided, mark as many boxes as apply in the BLS (left column) **(F, A, M, B, P, D, E, C, H, K, N, O, X, G, I, S, T, L, W, U)** or ALS (right column) **(B, D, E, T, F, G, 1, 2, 3, 4, O, P, N, C, Y, H, V, U)**. Mark each treatment or procedure only once, though it may have been done for this patient several times. Mark only those services provided by your unit. Document services provided by non-EMS individuals or other agencies in the "Narrative/Assessment" section of the 01A form. Other agencies must document services provided by their agency on their O1A form and F-1612 data form.

BLS SERVICES(*Fieldname*: CARE 1):(Care Rendered [Left Column])

(F)AED	when used on patient
(A)bag-valve mask	on resuscitation
(M)burn care	on burns
(B)axial spinal stabilization	on patient
(P)CPR/resuscitation	when preformed on patient
(D)decontamination	usually associated with exposure to hazardous materials
(E)extrication	from a vehicle or hazardous situation; if time > than 10 minutes, record the approx. time in the Narrative/Assessment section of the 01A form
(C)hard collar	to immobilize the neck
(H)hot/cold packs	on patient

(K)KED	on patient
(N)NP/OP airway	on attempts to establish a nasopharyngeal or oral pharyngeal airway
(O)OB assist	on assistance with obstetrical delivery
(X)oxygen	on administration to patient
(G)sand bags	used for patient
(I)snake bite kit	on patient
(S)splint, simple	on patient
(T)splint, traction	on patient
(L)suction	on patient
(W)wound dressing	on patient
(U)BLS Other	for a BLS procedure other than those listed

ALS SERVICES (*Fieldname*: CARE 2):(Care Rendered [Right Column])

(B)blood drawn	on patient
(D)dexstick	on patient
(E)EKG monitor	on patient (**also mark the "1 ST EKG" section**)
(T)EKG strip	on patient
(F)12 lead EKG	on patient
(G)McGill forceps	on an attempted or performed foreign body removal
(1)Meds given IV	route given to pt
(2)Meds given IO	route given to pt
(3)Meds given ET	route given to pt
(4)Meds given PO	route given to pt
(O)monitor chest tubes	on an attempted, inserted a chest tube, or monitored
(P)needle thoracostomy	on an attempted or performed needle thoracostomy
(N)NG insertion	on an attempted, inserted or monitored NG tube
(C)Percutaneous Needle Cric	if attempted, or inserted
(Y)Approved Device	Quick Trach Device
(H)TCP	if attempted or placed
(V)Valsalva maneuver	on patient
(U)ALS Other	for an ALS procedure other than those listed, for transfer patients mark this box if EMT-P is monitoring IV medication during the transfer.

SYS BP
Mark the box **(4-0)** next to the category in which the patient's initial systolic blood pressure reading falls. If no systolic BP is present, mark the space for "0." Blood pressures are usually obtainable on pediatric patients with a pediatric BP cuff. If you obtain no BP, leave this area blank. **LIST ONLY VITAL SIGNS TAKEN BY YOUR AGENCY**.

RESP RATE
Using the **first** observation of the patient's respiratory rate, mark the box **(4-0)** next to the category in which the patient's rate (in number of respiration's per minute) occurs. For example, if the patient's respiration rate is 20, mark the top space, numbered 4.

EFFORT
Referring to **initial** respiratory effort (chest wall movement), mark the box **(1 or 0)** next to the category that better describes the situation for this patient~normal, or shallow/refractive/none.

CAP REFILL
Mark the box **(2, 1, 0)** that best describes the patient's capillary refill upon **initial assessment**.

BEST MOTOR (*Fieldname*: MOTOR)
Mark the box **(6-1)** next to the patient's **initial** best motor response.

BEST VERBAL (*Fieldname*: VERBAL)
Mark the box **(5-1)** next to the category that describes this patient's **initial** best verbal response.

EYE OPEN
Note the patient's **initial** ability to open his/her eye(s). Mark the box **(4-1)** next to the category**.**

(R)cardiovert (D)defib (*Fieldname*: D-FIB)
Mark **(R)CARDIOVERT (D)DEFIB** if performed by the unit recording this run.

1ST EKG
Mark **one** box **(N, B, T, V, C, D, I, L, E, A, Y, O)** for the code of the **first rhythm detected** on EKG by unit recording this run, *as recorded on the 01A Narrative*.

(N)SR: Normal sinus rhythm
(B)SB: Sinus bradycardia; heart rate <60 beats per minute
(T)ST: Sinus tachycardia; heart rate >100 per minute
(V)Vfib: Ventricular fibrillation
(C)VT: Ventricular tachycardia (V tach)
(D)SVT: Super ventricular tachycardia
(I)Afib: Atrial fibrillation
(L)AFL: Atrial flutter
(E)AT: Atrial tachycardia
(A)AVB: Atrioventricular block (AV block) or heart block
(Y)ASY: Asystole
(O)Oth Unidentifiable rhythm

ATTEMPTS PLACED

IV (*Fieldnames*: IV ATTEMPT/IV2 ATTEMPT)
Mark **(1, 2, or 3+)** for three or more attempts to place IV needle. If successful, mark **(Y)**. For bilateral (or 3 or more) IV's, the number of IV attempts means the maximum number of attempts made to insert any of the needles. If both were placed successfully on the first try, mark "1." If one IV took two tries before placement, mark "2," etc.

IO (*Fieldnames*: IO ATTEMPT/IO2 ATTEMPT)
Mark **(1, 2, or 3+)** for three or more attempts to place IO needle. If successful, mark **(Y)**. For bilateral (or 3 or more) IO's, the number of IO attempts means the maximum number of attempts made to insert any of the needles. If both were placed successfully on the first try, mark "1." If one IO took two tries before placement, mark "2," etc.

ET (*Fieldnames*: ET1 ATTEMPT/ET1A ATTEMPT)
Mark **(1, 2, or 3+)** for three or more attempts to place tube. If successful mark **(Y).**

ET-NASAL (*Fieldname*: ET2 ATTEMPT)
Indicate placement of ET: **(N)**nasal or **(O)**oral.

PT CONDITION
Mark the patient's overall response to treatment. BLANK IS INVALID. This category refers to the patient's response to all treatment rather than to a specific drug or procedure. Mark **(C)changed** or **(N)no change** during transport.

IV/IO
Mark box for saline or **(S)** OR **(L)**

SPECIAL STUDY
Use this area whenever a special study is conducted. Mark all boxes **(M, S, or O)** that apply.
(M)Medications
(S)Skills
(O)other.

OUTCOME
Mark the box **(C, D, R, G, A, O)** next to the category that best describes this call. *BLANK IS INVALID*.

(C)canceled enroute: Call canceled by agency dispatcher prior to arrival at a scene and if the run is canceled on scene before you make pt contact.
(D)dry run-no pt No patient was found at the scene, the unit was unable to locate the scene or the patient, or the patient refuses to communicate so you cannot obtain any patient information.
(R)transport refused: The patient accepted care by an EMS field provider but refused to be transported by any EMS provider, and for walk-in patients.
(G)transport-ground: Patient received prehospital care, was transported by this or another ground ambulance, or if patient care was transferred to another unit.
(A)transport-air: Patient received prehospital care, was transported by helicopter or fixed-wing aircraft, and for patient to loading zone and patient care to EMS air.
(O)obviously dead: Patient showed obvious signs of death, per protocol.

WHY SELECTED
Mark the category **(T, P, D, C, E, R, O)** that most closely matches the reason for selection of the receiving hospital. If the base hospital indicates a reason, mark the hospital's determination of "why selected."

(T)major trauma: a trauma center is required.
(P)patient request: patient or patient's physician requests transport to a specific facility
(D)diversion: the original receiving hospital selected was on diversion
(C)closest: the hospital is closest to the scene.
(E)peds trauma: pediatric trauma center is required.
(R)reroute: the receiving hospital destination changed while the unit was enroute (e.g., a change in patient condition required selection of a different facility). Does not include change in a destination based upon hospital status
(O)other: a reason other than those listed was used in selecting the receiving hospital.

ICEMA# (*Fieldname*: ICEMA#2)
Mark six boxes **(0-9**) to indicate the ICEMA number printed on the upper left corner of the 01A Narrative form for this patient. An ICEMA number is required here, **except for dry runs or canceled calls**.

ATTENDANT #1 CERT NO (*Fieldnames*: CERT#1A/CERT#1B)
Mark the first box **(E, L, P, or M)** to indicate the level of accreditation/certification for primary patient caregiver reporting on this run. P for paramedic, E for emergency medical technician, or M for mobile intensive care nurse (on interfacility transfers). Mark the ICEMA accreditation/certification numbers **(0-9)** in the remaining boxes**.** If your ICEMA number is less than four digits, use zeroes before the number to fill the four boxes. **Provisional paramedics or MICNs who are third members of the ambulance crew sign the 01A narrative form, but enter no data on the F-1612 data form.**

ATTENDANT #2 CERT NO (*Fieldnames*: CERT#2A/CERT#2B)
Mark the first box **(E, L, P, or M)** to indicate the type of accreditation/certification for the secondary patient caregiver reporting on this run. Mark the ICEMA accreditation/certification number **(0-9)** in the remaining boxes. If your number is less than five digits, use leading zeroes before the number as needed to fill the boxes.

THIS FORM BY PROVIDER/UNIT (*Fieldnames*: PROVIDER B/UNIT B)
Obtain your 3-digit provider code from the list on the back of the F-1612 data form. Mark the box with these three digits **(0-9)** below "Provider." For all agencies, mark three numbers that represent the unit number of the vehicles in which you are riding on this call. Use leading zeroes.

TRANSP CODE2 (THIS FORM BY)
Enter the type of unit for the agency reporting this run.

(MA)Medic Ambulance
(MS)Medic Squad
(ME)Medic Engine
(AM)Ambulance
(SQ)Squad
(E)Engine

REVERSE SIDE OF F-1612 DATA FORM

PUBLIC PROVIDERS
Fire department EMS providers, use provider code followed by the unit type (MA, ME, MS, AM, SQ, E) and three-digit unit number as assigned by Fire Chiefs. **Use code 888 for other Public Providers outside the ICEMA region**.

PRIVATE PROVIDERS
A three-digit code is assigned to each private ALS or BLS provider agencies within the region. Provider codes are used in the area for "Other Transport Provider" on the F-1612 data form (upper right corners) as well as for the "This Form By" provider code in the lower right corner. Codes are organized alphabetically by county. The provider code is followed by a three-digit unit number assigned by ICEMA, e.g., 001. **Use code 999 for other Private Providers outside the ICEMA region.**

HOSPITAL CODES
Two-digit code numbers have been assigned to each hospital within the ICEMA region. These codes are used in the "Base Hospital" and "Receiving Hospital" areas of the F-1612 data form. They are listed alphabetically by hospital name. **Use code 88 for all hospitals outside the ICEMA region**.

INCIDENT CITY CODES
These three-digit code numbers are to be used to complete the "City" area in the upper right portion of the F-1612 data form. To find a code, first locate the section of the form for the appropriate county within the region (Inyo, Mono, or San Bernardino). For San Bernardino County, check the subheadings for the appropriate geographical area (e.g., West Valley or High Desert). Cities and communities are listed alphabetically within the county or area. If the city or community where the incident occurred is not listed, use the code for the city or community nearest to the incident location; if none, use the code for "Inyo Co. Other," "Mono Co. Other," or "San Bernardino Co. Other," as appropriate.

INSTRUCTIONS FOR SUBMITTING DATA VIA EMAIL

The data fields were taken from the State EMS regulations (Title 22) for an EMT-P patient care record and items recommended by the State EMS Data Study Task Force, which include items suitable for computerization. The data fields are required for evaluation of the EMS State grant contract and include key fields necessary to provide required reports, edit, and cross-referencing with dispatch and E.D. logs. The data should be submitted within thirty days following the Run Date and must include all the provider agency runs where they made patient contact, canceled calls and dry runs. **The provider agency should edit all their own records for any missing data and invalid codes before submitting it to ICEMA** at Memanuel@dph.sbcounty.gov. The data file format is a comma delimited ASCII File with a .txt file extension. Dates are in the Year-Month-Day format; e.g., 20040601 is June 01, 2004. The data fields MUST be in the **EXACT** order as listed below and in the correct starting position in the data set.

FIELD NAME	*STARTING POSITION IN DATA FILE*	*DEFINITION*	*LENGTH*	*VALID CHARACTERS*
GENDER (SEX)	1	Patient gender	1	M,F,U
INS0	2	End of field	1	Comma
AGE	3	Patient age, in whole years *Blank if unknown*	2	Numerics: 0-9
INS1	5	End of field	1	Comma
ZIP (Zip Code)	6	First 5 digits of patients mailing address zip code	5	Numerics: 0-9
INS2	11	End of field	1	Comma
PTS (#Pts)	12	Number of patients at this incident scene *Or blank*	1	Numerics: 0-9
INS3	13	End of field	1	Comma
INCIDENT#	14	Provider agency incident/dispatch #	8	Numerics: 0-9
INS4	22	First 2 Numbers of the Year 2000	3	,20
RUN-YEAR1	25	Third Number of Year in 2000	1	9,0,1
RUN-YEAR2	26	Fourth Number of Year in 2000	1	Numerics: 0-9
RUN-MONTH	27	Month	2	Numerics: 0-9
RUN-DAY	29	Day	2	Numerics: 0-9
INS5	31	End of field	1	Comma
CITY	32	Incident location *e.g., use 888 For County Jail*	3	Numerics: 0-9
INS6	35	End of field	1	Comma
RUN TO CODE (Run Code-To)	36	Code TO scene	1	1, 2, 3
INS7	37	End of field	1	Comma
RUN FR CODE (Run Code-From)	38	Code FROM scene	1	1,2,3
INS8	39	End of field	1	Comma
PROVIDER A (Other Transport-Provider)	40	Provider code of another provider on scene. *See back of Scantron form for valid codes. Enter this information only if a second unit is on scene and makes patient contact*	3	Numerics: 0-9
INS9	43	End of field	1	Comma
UNIT A (Other Transport-Unit)	44	Unit number of another provider on scene. *See back of Scantron form for valid codes. Enter this information only if a second unit is on scene and makes patient contact*	3	Numerics: 0-9
INS10	47	End of field	1	Comma
ICEMA#1 (Other ICEMA #)	48	Enter another agency's 01A form number whenever another ALS provider is on scene and	6	Numerics: 0-9

FIELD NAME	*STARTING POSITION IN DATA FILE*	*DEFINITION*	*LENGTH*	*VALID CHARACTERS*
		makes contact with the same patient. *This field cross-references multiple forms completed on the same patient/same incident*		
INS11	54	End of field	1	Comma
PRIOR CARE	55	Enter the Identifying care giver, if any, prior to arrival of unit	1	N,M,B,C,O,L,A
INS12	56	End of field	1	Comma
INJURY MECH (Mech of Injury-Trauma Only)	57	Enter the one category that best describes the mechanism of injury precipitating this call	1	M,C,G,S,A,D,F,B,L,T,P,O,U
INS13	58	End of field	1	Comma
SEATBELT (Auto/Truck MVA)	59	Enter if patient was wearing a seatbelt or other safety restraint. **MUST be entered for all MVA's.**	1	Y,N,U
INS14	60	End of field	1	Comma
HELMET (Motorcycle)	61	Enter if patient was wearing a protective helmet. **MUST be entered for all MVA's involving motorcycles or bicycles.**	1	Y,N,U
INS15	62	End of field	1	Comma
CATEGORY	63	Enter the ONE category that best fits this patient	1	T,C,R,A,B,5,U,D,E,O,P,S,M,N
INS16	64	End of field	1	Comma
BASE HOSP	65	Enter the Base Hospital Code only if BH was contacted	2	Numerics: 0-9
INS17	67	End of field	1	Comma
NO CONTACT	68	Enter if no BH contact attempted/needed, RCF or contact was with receiving hospital only	1	Y
INS18	69	End of field	1	Comma
RECV HOSP	70	Enter the valid code of RH, leave blank if patient refuses transport or if another provider is transporting the patient	2	Numerics: 0-9
INS19	72	End of field	1	Comma
CALL RCD	73	Enter the time call received by provider agency dispatch, in military time *4:16 p.m.=1616*	4	Numerics: 0-9
INS20	77	End of field	1	Comma
EN ROUTE	78	Enter the time unit *leaves* to scene	4	Numerics: 0-9
INS21	82	End of field	1	Comma
TIME ARRIVE (Times-Arrive)	83	Enter the time unit *arrives* at scene and wheels stop	4	Numerics: 0-9
INS22	87	End of field	1	Comma
TIME DEPART (Times-Depart)	88	Enter the time unit *departed* scene to hospital	4	Numerics: 0-9
INS23	92	End of field	1	Comma
ARV DESTIN (Arv Dest)	93	Enter the time unit *arrives* at hospital	4	Numerics: 0-9
INS24	97	End of field	1	Comma
REFUSE CARE	98	Enter when patient declines ALL prehospital treatment, if the patient refuses one or more specific types of care, document on the O1A form	1	Y
INS25	99	End of field	1	Comma
MEDICATION	100	Enter only medications given by the unit recording this run	24	A,H,B,J,P,K,D,1,2,E,Q,F,G,L,R,S, M,N,3,W,C,4,V,U
INS26	124	End of field	1	Comma

FIELD NAME	*STARTING POSITION IN DATA FILE*	*DEFINITION*	*LENGTH*	*VALID CHARACTERS*
CARE 1 (Care Rendered [Left Column])	125	Enter only BLS services given by the unit recording this run	20	F,A,M,B,P,D,E,C,H,K,N,O,X,G,I, S,T,L,W,U
INS27	145	End of field	1	Comma
IV/IO (IV-Saline) (added to field name)	146	Enter type of IV solution given by the unit recording this run	1	S,L
INS28	147	End of field	1	Comma
CARE 2 (Care Rendered [Right Column])	148	Enter only ALS services given by the unit recording this run	18	B,D,E,T,F,G,1,2,3,4,O,P,N,C,Y,H, V,U
INS29	166	End of field	1	Comma
SYS BP	167	Enter the category in which the patient's initial systolic blood pressure reading falls, if not present, enter 0, leave blank if no BP is obtained. Enter ONLY vital signs taken by the unit recording this run	1	Numerics: 4-0
INS30	168	End of field	1	Comma
RESP RATE	169	Enter first observation of patient's rate	1	Numerics: 4-0
INS31	170	End of field	1	Comma
EFFORT	171	Enter initial respiratory effort of patient	1	1,0
INS32	172	End of field	1	Comma
CAP REFILL	173	Enter initial cap refill of patient	1	2,1,0
INS33	174	End of field	1	Comma
MOTOR (Best Motor)	175	Enter initial motor response of patient	1	Numerics: 6-1
INS34	176	End of field	1	Comma
VERBAL (Best Verbal)	177	Enter initial verbal response of patient	1	Numerics: 5-1
INS35	178	End of field	1	Comma
EYE OPEN	179	Enter initial eye opening response of patient	1	Numerics: 4-1
INS36	180	End of field	1	Comma
D-FIB (Cardiovert/dfib)	181	Enter if performed by the unit recording this run	1	R,D
INS37	182	End of field	1	Comma
1ST EKG	183	Enter code for first rhythm detected on EKG by unit recording this run	1	N,B,T,V,C,D,I,L,E,A,Y,O
INS38	184	End of field	1	Comma
IV ATTEMPT (Attempts Placed-IV)	185	Enter the number of IV attempts	1	1,2,3
INS39	186	End of field	1	Comma
IV2 ATTEMPT (Attempts Placed-IV-Y)	187	Enter ONLY if IV placed successfully	1	Y
INS40	188	End of field	1	Comma
ET1 ATTEMPT (Attempts Placed-ET)	189	Enter the number of ET attempts	1	1,2,3
INS41	190	End of field	1	Comma
ET1A ATTEMPT (Attempts Placed-Y)	191	Enter ONLY if ET placed successfully	1	Y
INS42	192	End of field	1	Comma
ET2 ATTEMPT (Attempts Placed-ET-Nasal)	193	Enter placement of ET	1	N,O
INS43	194	End of field	1	Comma

FIELD NAME	*STARTING POSITION IN DATA FILE*	*DEFINITION*	*LENGTH*	*VALID CHARACTERS*
PT CONDITION	195	Enter patient's overall response to treatment. **BLANK IS INVALID**	1	C,N
INS44	196	End of field	1	Comma
OUTCOME	197	Enter category that best describes call. **BLANK IS INVALID**	1	C,D,R,G,A,O
INS45	198	End of field	1	Comma
WHY SELECTED	199	Enter category that matches reason for selecting RH	1	T,P,D,C,E,R,O
INS46	200	End of field	1	Comma
ICEMA#2 (ICEMA#)	201	Enter ICEMA 01A report form number by unit recording this run	6	Numerics: 0-9
INS47	207	End of field	1	Comma
CERT#1A (Attendant #1 Cert No.-Alphas)	208	Enter type of accreditation/certification for primary patient caregiver reporting on this run.	1	E,L,P,M
CERT#1B (Attendant #1 Cert No.-Numerics)	209	Enter ICEMA four-digit accreditation/certification number for primary patient caregiver reporting on this run.	4	Numerics: 0-9
INS48	213	End of field	1	Comma
CERT#2A (Attendant #2 Cert No.-Alpha)	214	Enter type of accreditation/certification for secondary patient caregiver reporting on this run.	1	E,L,P,M
CERT#2B (Attendant #2 Cert No.-Numerics)	215	Enter ICEMA four or five-digit accreditation/certification number for secondary patient caregiver reporting on this run.	5	Numerics: 0-9
INS49	220	End of field	1	Comma
PROVIDER B (This Form by-Provider)	221	Enter the valid provider code for the agency reporting this run	3	Numerics: 0-9
INS50	224	End of field	1	Comma
UNIT B (This Form by-Unit)	225	Enter the valid unit code for the agency reporting this run	3	Numerics: 0-9
INS51	228	End of field	1	Comma
SCANTRON#/LITHOCODE	229	Binary Summation Leave 6 spaces blank	6	Leave no marks in this field
INS52	235	End of field	1	Comma
TRANSP CODE1 (OTHER TRANSPORT-Top right of Scantron form)	236	Enter the type of unit for another provider on scene. *Enter this information only if a second unit is on scene and makes patient contact*	2	MA,MS,ME,AM,SQ,E
INS53	238	End of field	1	Comma
TRANSP CODE2	239	Enter the type of unit for the agency reporting this run	2	MA,MS,ME,AM,SQ,E
INS54	241	End of field	1	Comma
SP STUDY (Special Study)	242	Enter category ONLY if reporting data for a special study	3	M,S,O
INS55	245	End of field	1	Comma
RELEASE SIGNED	246	Enter if AMA was signed on 01A Form	1	Y
INS56	247	End of field	1	Comma
IO ATTEMPT (Attempts Placed-IO)	248	Enter the number of IO attempts	1	1,2,3
INS57	249	End of field	1	Comma
IO2 ATTEMPT (Attempts Placed-IO-Y)	250	Enter ONLY if IV placed successfully	1	Y